Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative Box
#01

MFDR Tracking Number
M4-11-3787-01

MFDR Date Received
JUNE 29, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The disputed fees should be paid in accordance with DWC Rule 134.404. Hospital Facility Fee Guidelines – Inpatient. According to DWC Rule 134.404, the MAR for this procedure is $72,657.62, however the carrier only recommended $49,663.57 as the implants were grossly underpaid."

Amount in Dispute: $23,380.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon review, it is this Carrier's position that: No additional reimbursement is due for the facility specific reimbursement amount. The requestor did not provide a claims substantive explanation in response to the network reduction taken by the carrier. No additional reimbursement is due for invalid, non implantables billed as implantables, or for implantables that were not properly billed in a timely manner. The requestor billed supplies/instruments that are not implantables and that are not necessary to operate, program or recharge implantables. The requestor did not properly bill the anterior fusion implantables or the posterior fusion implantables with supporting documentation in a timely manner…In conclusion, no additional reimbursement is due for the facility specific reimbursement or implantables. The charges in dispute were not found to be due reimbursement as implantable and or were not properly billed in a timely manner."

Response Submitted by: UniMed Direct, P. O. Box 535489, Grand Prairie, TX 75053

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 16, 2010 through August 20, 2010	Inpatient Hospital Surgical Services	$23,380.71	$19,299.12

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility

fees for inpatient services.

3. 28 Texas Administrative Code §133.20 give guidelines for medical bill submission by health care providers
4. 28 Texas Administrative Code §133.250 sets out guidelines for reconsideration of medical bills
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 100 — ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE.
   - 111-011 — COVENTRY CONTRACT STATUS INDICATOR 11 – NEGOTIATED OR OTHER PRICING.
   - 150 — Payer deems the information submitted does not support this level of service. $3,999.00
   - 193 --- Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 649-008 — REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE WITH A SEPARATE ALLOWANCE FOR IMPLANTABLES.
   - 649-006 — REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE WITH A SEPARATE ALLOWANCE FOR IMPLANTABLES.
   - 45 — Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
   - 861-000 — PAYMENT ADJUSTED AS INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE. DOCUMENTATION SUBMITTED DOES NOT JUSTIFY LEVEL OF SERVICE. UMD RECOMMENDS $3,999.00
   - 901--- RECONSIDERATION NO ADDITIONAL PAYMENT. ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
   - W1— Workers Compensation State Fee Schedule Adjustment
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $1,169.97
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $1,315.76
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $1,934.94
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $144.74
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $2,786.32
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $2,828.50
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $26,547.42
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $281.72
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $3,719.07
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $3,926.00
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $30.96
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $310.48
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $349.07
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $4,179.48
   - 085 — DUE TO NETWORK ADJUSTMENTS, REVIEW OF THIS BILL HAS RESULTED IN A REIMBURSEMENT OF $85.52
   - 45 — Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). $1,160.97
   - 45 — Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). $1,315.76
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(Use Group Codes PR or CO depending upon liability). $1,934.94
- 45 — Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). $144.74
- 45 — Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). $2,786.32
- 45 — Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). $25,547.42
- 45 — Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). $281.72
- 45 — Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). $3,719.07
- 45 — Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). $3,926.00
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- W1 — Workers Compensation State Fee Schedule Adjustment

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Did the Healthcare provider bill the insurance carrier in accordance with Texas Administrative Code §133.20 and §133.250?
3. Which reimbursement calculation applies to the services in dispute?
4. Is the bone marrow aspirate considered an implantable per Texas Administrative Code §134.404(b)(2)? Are the devices used to obtain the bone marrow aspirate considered implantables per Texas Administrative Code §134.404(b)(2)?
5. What is the maximum allowable reimbursement for the services in dispute?
6. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The insurance carrier reduced disputed services with reason code "1-(45) – Charge exceeds fee/schedule/maximum allowable or contracted legislated fee arrangement" Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 21, 2011 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the healthcare provider carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per the respondent's position statement "The requestor did not properly bill the anterior fusion implantables or the posterior fusion implantables with supporting documentation in a timely manner". Per Texas Administrative Code §133.20 "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Review of the submitted documentation finds that the dates of service were August 16th-20th, 2010 and the respondent first audited the bill on September 21st 2010 which falls within the 95 day timeframe. Per Texas Administrative

Code§133.250(b) "The health care provider shall submit the request for reconsideration no later than eleven months from the date of service". Review of the documentation finds that the requestor submitted reconsideration to the insurance carrier in a timely manner. Additionally, the respondent did not deny any of the disputed services with a denial reason stating the bills or requested documents were not timely filed. The Division finds that the requestor billed the services in dispute and submitted reconsideration requests in accordance with Texas Administrative Code §133.20 and §133.250.

3. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

4. Per the respondent's position statement "The demineralized bone matrix (DMB) aspiration kit, Nuvasive vision system (Neurovision), and spine access system (MaXcess) are instruments/supplies that are covered under the facility specific reimbursement and are NOT implanted or necessary to operate, program or recharge the real implantables. Therefore, no reimbursement is due under the implantable reimbursement for the NON implantable demineralized bone matrix (DBM) aspiration kit, Nuvasive vision system (Neurovision) and spine access system (MaXcess)."
   Per Texas Administrative Code §134.404(b)(2) "Implantable" means an object or device that is surgically: (A) implanted, (B) embedded, (C) inserted, (D) or otherwise applied, and (E) related equipment necessary to operate, program and recharge the implantable."
   The requestor has submitted invoices for "Bone Marrow Aspiration Needle 11GA X 150MM" for $263, "NVM5 EMG Needle Kit w/XLIF Kit" for $2,539, and "MaXcess Sterile Disposable Kit" for $2151, and requested separate reimbursement under TAC §134.404(g). Review of the operative report submitted by the requestor finds that the bone marrow aspirate does not meet the definition of an implantable per TAC §134.404(b)(2). As the bone marrow aspirate is not considered an implantable, the "Bone Marrow Aspiration Needle 11GA X 150MM" and the "NVM5 EMG Needle Kit w/XLIF Kit" do not meet the definition of an implantable per §134.404(b)(2)(E) and will not be considered for payment under subsection (g) of 134.404.
   Review of the documentation finds that the "MaXcess Sterile Disposable Kit" is used for surgical exposure only and would not meet the definition of implantable per §134.404(b)(2). Hence, the "MaXcess Sterile Disposable Kit" will not be considered for payment under subsection (g) of 134.404.

5. §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
3300I11462	IMP SEA-SP SCR 6.5 X 45 MM	MALIBU POLYAXIAL SCREW, 6.5 x 45	2 at 1,319.00	$2,638.00	$2,901.80

		MM	EACH		
3300I11464	IMP SEA-SP LOCKING CAP	LOCKING CAP	2 at $411.00 EACH	$822.00	$904.20
3300I11567	IMP SEA-SP ROD 5.5 X 500MM	PRECONTOURED ROD 5.5 X 50 MM	1 at $499.00 EACH	$499.00	$548.90
3300I15322	IMP ISOTIS PUTTY 5CC DBM	ACCELL EVO3 5 CC	1 at $1,250.00 EACH	$1,250.00	$1,375.00
3300I14355	IMP SEA-SP OSTEOSPONGE STRIP	OSTEOSPONGE STRIP, 26MMX19MMX7 MM	1 at $1,570.00 EACH	$1,570.00	$1,727.00
3300I16813	IMP NV-SP CAGE 10X18/50MM	10X18X50MM – 10 DEG COROENT XL-F	1 at $7,134.00 EACH	$7,134.00	$7,847.40
3300I16169	IMP NV-SP BOLT 5.5 X 50 MM	XL-F SCREW VARIABLE 5.5 X 50 MM	2 at $1,195.00 EACH	$2,390.00	$2,629.00
3300I06998	IMP SURGICEL 2 X 14”	SURGICEL HEMO 2 X 14	1 at $1,538.06 EACH	$1,538.06	$1,691.87

$17,841.06	$19,625.17
Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

6. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

   - Documentation found supports that the DRG assigned to the services in dispute is DRG 454, and that the services were provided at Pine Creek Medical Center. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $45,682.89. This amount multiplied by 108% results in an allowable of $49,337.52.
   - The total cost for implantables is $17,841.06. The sum of the add-ons does not exceed the $2000 allowed by rule; for that reason, the total allowable amount for implantables is $17,841.06 plus $1,784.11, which equals $19,625.17.

   Therefore, the total allowable reimbursement for the services in dispute is 49,337.52 plus $19,625.17, which equals $68,962.69. The respondent issued payment in the amount of $49,663.57. Based upon

the documentation submitted additional reimbursement in the amount of $19,299.12 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $19,299.12 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		July 24 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.